The Nursing Home Initiative: Results at Year I
June 30, 1999

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Mr. Chairman and Members of the Committee,

My name is Dr. Andrew Kramer and I am a Professor of Geriatric Medicine at the University of Colorado Health Sciences Center. I provided testimony last July in relation to activities that our research team conducted in support of the GAO report on quality of care in California nursing homes. I discussed limitations in the state survey process and methods that we used in the GAO study to detect quality of care problems in nursing homes. Today I would like to cover four points. First, quality of care in nursing homes continues to be a major problem. Second, attempts to assess and improve quality of care in nursing homes over the past decade have met with little success. Third, a major change is required in the process by which quality of nursing home care is assessed and assured. Fourth, several steps are necessary for such a major change to occur.

I . Quality of care problems in nursing homes.

Quality of care remains a major problem in U.S. nursing homes. Problems our Center found in at least one-third of facilities in 1998 include malnutrition, pressure ulcer care, losses in physical function, falls, and response to acute illness. In at least 20% of facilities, significant problems were found relating to pain management, incontinence care, restraint use, antipsychotic use, personal care, and rehabilitation. For many of these problems, effective care management strategies exist, but are not implemented.

Taking pressure ulcers for example, data over the last 10 years from numerous investigations show that 11% of nursing home residents develop pressure ulcers often in the first six months of nursing home residence. Pressure ulcers cause pain in over half of the affected individuals and are associated with increased morbidity such as infections and sometimes death. However, proven strategies to prevent pressure ulcers are available and widely accepted treatment guidelines exist that could substantially reduce the problem of pressure ulcers. While some nursing homes are able to achieve pressure ulcer rates of zero among high-risk patients -proving that pressure ulcers can be prevented with good care -- other nursing homes have rates over 35%. And pressure ulcers are an easier problem to identify and treat than many other nursing home quality problems such as malnutrition.

2. Attempts to assess and improve quality of nursing home care have met with little success.

With more than 17,000 nursing homes in the U.S. - three times as many nursing homes as acute care hospitals - assuring quality of care is a formidable task. Of the 1.8 million residents in nursing homes, more than 50% have dementia, many have no living relatives, and on average they are dependent in 3 to 4 personal care activities, making them extremely vulnerable and unable to advocate for themselves. Federal regulatory efforts such as the Nursing Home Reform Act (OBRA 1987) have had some effect on use of physical restraints and psychotropic medications, but there is little evidence for an effect on overall quality of care, as this Committee's hearing last June revealed.

An illustrative example of this chronic failure can be found in the area of pressure ulcers. Remembering that pressure ulcers are conspicuous and largely preventable, a study of OBRA 1987 found that the nursing home survey missed quality of care problems in 64% of the nursing homes where an

independent survey found problems. A state, federal, and private sector initiative in Ohio to prevent pressure ulcers involving feedback of MDS data had absolutely no effect on pressure ulcer rates. The Joint Commission on Accreditation of Healthcare Organizations survey did not detect pressure ulcer problems in any of four facilities where such problems were found by an independent survey. Finally, a HCFA demonstration using MDS data in the survey process had a minimal effect on the detection of pressure ulcer quality problems. Implementation was a major problem in four of the six states, but even in the two states that used MDS data, the ability of the survey to detect quality of care problems was only marginally improved. Thus, pressure ulcer rates remain unnecessarily high and detection of quality problems remains unacceptably low.

3. A major change to the survey process is required to assure quality of care.

This conclusion was reached by this committee nearly a year ago. And we must remain committed to a major change in the survey process if we are serious about improving quality of nursing home care. We need a new method for sampling residents, a rigorous and standardized approach for collecting resident-level information and a decision-making process that is driven by documented, well-organized information.

On-site activities in the survey should begin with selection of both random and high-risk resident samples, including new admissions to the facility, for collection of standardized information on all relevant quality indicators. Surveyors should record responses to specific questions from chart review, staff interviews, resident interviews, and observations. This approach assures that all quality of care indicators are included in the survey; it standardizes the approach among surveyors and across facilities; and it provides the basis for the facility to be evaluated relative to other facilities. Comparison with national norms, that would be contained on surveyors' laptop computers, then provides the basis for focusing the review in each facility on adverse outcomes that occur at higher rates than expected. Following this initial comprehensive assessment, where problem areas are identified, a standardized, in-depth review of residents experiencing adverse outcomes should be conducted to establish the link to the underlying care that led to the adverse outcome. The findings should then be synthesized using a laptop computer such that scope and seventy of problems are more consistently assessed and a facility report is generated that yields specific information on adverse outcomes and the related care. Such protocols that structure survey activities and decisions are necessary to ensure that surveyors systematically assess quality of care in each facility.

4. What is necessary for this major change.

Our University of Colorado research team and the University of Wisconsin team have been selected to assist HCFA in developing this new survey. This effort is in the very early stage of development. However, if such a major change is going to be made in the survey process by the end of the year 2000, a much more concerted effort will be required. This will require commitment at the most senior levels of HCFA and additional HCFA staff whose sole responsibility is this fundamental, longer-term change in the survey process. Continued support from Congress will be necessary throughout the project.

To illustrate the complexity of this work, refinement and testing of all methods involving surveyors is necessary on a large scale before national implementation. This will require commitment and resources. While a software package is available, further software development is necessary and laptops are required in all states. Strategic planning must begin now to engage surveyors, the industry, and other stakeholders to understand their needs and responsibilities. Finally, state agencies need to be informed that this change is on the way and how to prepare for it.

Let me leave you with a couple thoughts. Of people 65 years of age, 43% will spend some time in a nursing home. I wish I could say that small changes in the nursing home survey process can lead to big improvements in quality of care, but the evidence indicates just the opposite. We need a major change in the survey process. The quality of care survey that UCHSC has been conducting for the past five years suggests that a more thorough and consistent survey process is within our reach. But it will take resources and commitment to make the changes that are necessary to improve quality of care for the elderly in this country. Let us not waste any time.